South Carolina
Department of Health and Human Services

Forward completed form to: Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

MEDICAID ENROLLMENT DATA
GROUP COMMUNITY LONG TERM CARE PROVIDER - NON-CONTRACTED

[redacted] ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE [redacted]CAID PROVID
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON [redacted] BACK OF T[redacted]ORM.

[redacted] 6 2 [redacted]

3 PROVIDER'S NAME

5 Tax Payer Identification Name

Physical Location Address
7 NUMBER AND STREET

9 CITY

10 STATE 11 ZIP

Payment Address (If different from mailing address)
6 In care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

12 City

13 STATE [redacted]IP

15 COUNTY*

16 TELEPHONE ([redacted])

17 IRS EMPLOYER ID NO.

[redacted] N [redacted]

22 LIST NAMES AND SC MEDICAID NUMBERS [redacted]NDIVIDUAL PROVIDERS who participate in your Medicaid group.
Medicaid numbers are not required when an Individu[redacted] Enrollment Form is attached.

Provider Name	Medicaid N[redacted]

Provider Name	Medicaid Number

[redacted]D.

24 NPI ISSUE[redacted]ATE

25 Taxonomy Code

[redacted] Taxonomy Code

[redacted]tatistically valid ra[redacted]ampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I [redacted]at I have read the condit[redacted]of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side [redacted]is form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollme[redacted]further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for proce[redacted]Medicaid claims.

Signature and Tit[redacted]Agent: _____ Date _____
A facsimile stamp[redacted]eptable.

DHHS Form 219-CLTCGNC (May 2006)